No. 98-1949

IN THE
Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION, and HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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QUESTION PRESENTED

Whether a health maintenance organization ("HMO") and its physicians breach a fiduciary duty under section 404(a)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1104(a)(1), by implementing a managed-care program in which the HMO and its physicians receive financial incentives to provide medical care to the HMO's enrollees in a cost-effective manner.

PARTIES TO THE PROCEEDING

All parties to the proceeding are listed in the caption of the case. There are no additional parent companies or nonwholly owned subsidiaries of the parties. See Sup. Ct. R. 29.6.

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The opinion of the court of appeals and the dissent thereto (App. 1a-47a) were entered on August 18, 1998, and are reported at 154 F.3d 362 (7th Cir. 1998). The order of the court of appeals denying the petition for rehearing and the suggestion for rehearing *en banc* was entered on March 8, 1999; that order and the dissent from the denial of rehearing *en banc* (App. 48a-58a) are reported at 170 F.3d 683 (7th Cir. 1999). The opinion of the United States District Court for the Central District of Illinois, adopting the magistrate judge's recommendation that petitioners' motion to dismiss Count III of respondent's amended complaint (the count at issue here) should be granted (App. 59a-60a), is not reported. The recommendation of the magistrate judge (App. 61a-64a) is not reported. A previous opinion of the district court, granting petitioners' motion for summary judgment on two state-law counts in respondent's complaint, but also granting respondent leave to amend her complaint to state a claim under the Employee Retirement Income Security Act (App. 65a-80a), is not reported. The February 10, 1997 judgment of the district court reflecting the jury verdict in this case (App. 81a-82a) is not reported.

JURISDICTION

The court of appeals entered its judgment on August 18, 1998. Petitioners timely filed a petition for rehearing and suggestion for rehearing *en banc* on September 1, 1998. On March 8, 1999, the court of appeals issued its decision and order denying petitioners' petition for rehearing and suggestion for rehearing *en banc*. App. 48a-58a. Petitioners timely filed their petition for certiorari on June 4, 1999, and this Court granted the petition on September 28, 1999. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTE INVOLVED

The statute involved in this case is the Employee Retirement Income Security Act of 1974 ("ERISA"), specifically section 3(1), 29 U.S.C. § 1002(1), which is set forth *infra* at 22, section 3(21)(A), 29 U.S.C. § 1002(21)(A), which is set forth *infra*, at 20, and section 404(a)(1), 29 U.S.C. § 1104(a)(1), which provides:

> [A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and --
>
> (A) for the exclusive purpose of:
>
> (i) providing benefits to participants and their beneficiaries; and
> (ii) defraying reasonable expenses of administering the plan;
>
> (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

STATEMENT OF THE CASE

1. In the decision below, the court of appeals held that a health maintenance organization ("HMO") and its owner physicians act as fiduciaries within the meaning of ERISA when they implement a system of managed care in which they earn additional income if the HMO succeeds in providing cost-effective care. The court also held that the allegation that an

HMO and its physicians have adopted such a mechanism states a claim for breach of fiduciary duty under ERISA.

This case is the product of the relatively recent, substantial changes in the method by which health care is delivered and paid for in this country. Traditionally, health care in the United States was provided on a fee-for-service basis, and physicians and other providers of medical services were separate from the entities responsible for paying for that health care (usually, insurers). A physician provided the medical treatment; bills were submitted to an insurer which paid those bills pursuant to the terms of the insurance contract. In the late 1960s and early 1970s, rapid and dramatic increases in health-care costs led to the development of alternative forms of health-care delivery and financing, including HMOs, preferred-provider organizations, and other forms of "managed care."

Generally, in a managed-care arrangement, enrollees receive comprehensive health-care coverage in exchange for a fixed premium. A managed-care organization arranges for the enrollees' care by employing or entering into independent contracts with providers. Because managed-care organizations generally assume some or all of the financial risk of providing health care, they have a strong incentive to control costs and to provide preventive care. Costs are "managed" through a variety of administrative mechanisms, such as utilization review, medical necessity determinations, and pre-certification of care. See, *e.g.*, *American Mfrs. Mut. Insurance Co.* v. *Sullivan*, 119 S. Ct. 977, 982-83 (1999); *FTC* v. *Indiana Federation of Dentists*, 476 U.S. 447, 449 (1986). These devices are often linked with financial incentives for participating physicians to reduce the utilization of unnecessary or overly costly services.[1]

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[1] U.S. General Accounting Office, GAO/HRD-94-3, *Managed Health Care -- Effect on Employers' Costs Difficult to Measure* 4-5 (1993) ("GAO Report"); (continued...)

Cost-containment measures are now routinely used by health insurers and managed-care organizations.[2] In addition, a substantial majority of HMOs use financial rewards and penalties for health-care professionals to provide incentives for cost-effective treatment.[3]

Congress has recognized and sought to support the development of managed-care arrangements. In the early 1970s, faced with an explosive increase in medical costs, Congress decided that HMOs represented an important alternative to traditional fee-for-service medicine and that the development of this alternative was threatened by the hostility of state regulators. In response to these concerns, Congress enacted the HMO Act of 1972. The HMO Act expressly authorized and approved the HMO arrangement for health-care delivery. It *required* HMOs to assume financial risk for the care of participants and specifically authorized HMOs to enter into contracts that financially reward their physicians for minimizing expensive treatment:

> Each [HMO] shall . . . assume full financial risk on a prospective basis for the provision of basic health services, except that a[n] [HMO] may . . . make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions. [42 U.S.C. § 300e(c).]

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[1] (...continued)
D. C. McGraw, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose these to Patients?* 83 Geo. L.J. 1821, 1821 (1995) (citing Stanley S. Wallack, *Managed Care: Practice, Pitfalls and Potential*, Health Care Financing Rev. 1991, Ann. Supp. 27)).

[2] *See also* McGraw, *supra*, at 1823 & n.12.

[3] *See* GAO Report, *supra*, at 30; McGraw, *supra*, at 1827 n. 39 (citing M. Rodwin, *Medicine, Money and Morals* 140 (1993)).

In addition, to shield HMOs from state regulation designed to undermine their basic purposes, the HMO Act preempted "state laws which impair the formation or operation of health maintenance organizations and health service organizations." S. Rep. No. 93-129 (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, 3057 (referring to 47 U.S.C. §300e-10(a)).

The legislative history emphasized that Congress intended the HMO Act affirmatively to foster the growth of HMOs and to give employers and consumers an alternative to traditional fee-for-service arrangements. *Id.* at 3034. As noted in a Senate Committee Report, a principal virtue of HMOs is that they incur a financial risk in providing care and therefore have an incentive to contain costs:

> The fixed price concept for comprehensive services provides a strong financial incentive to physicians, hospitals and other institutional providers of health care services to place greater emphasis on preventative services to avoid the need for costly, intensive care *which can reduce their income.* At the same time, HMO's are motivated to function more efficiently since the costs of wasteful and inefficient practices cannot be passed on to the consumer or to third party payers. [*Id.* (emphasis supplied).]

Likewise, Congress has encouraged the development of managed-care options in the Medicare and Medicaid programs. See 42 U.S.C. § 1395mm (Medicare); *id.* § 1396b(m) (Medicaid). And in the Balanced Budget Amendments of 1997, Congress further authorized Medicare to contract for health

services from risk-bearing "provider-sponsored organizations" -- entities formed by hospitals or physicians -- even if those entities do not otherwise meet the requirements of state insurance and HMO laws. See *id.* § 1395w-25.[4]

The result of the rising cost of fee-for-service health care and the above-described regulatory developments has been the rapid proliferation of HMOs and other managed-care arrangements. Numerous employers have moved away from providing health benefits under the traditional fee-for-service system and now sponsor ERISA plans which offer health-care coverage through managed-care arrangements. The issue in this case is whether a commonplace example of such a plan is unlawful under ERISA.

2(a). State Farm Insurance Company and petitioner, Health Alliance Medical Plans, Inc. ("HAMP"), entered into a contract for group health insurance.[5] In that contract, HAMP agreed that it would arrange medical and hospital services for State Farm employees and their families through a health maintenance organization ("HMO") -- pre-paid health insurance which, for a fixed monthly payment per family or individual, provides delineated health-care coverage. Specifically, HAMP stated that it would arrange coverage "in accordance with the Subscription Certificate" through petitioner, the Carle Clinic Association, doing business as the CarleCare HMO. See Group Subscription Certificate (App. 93a) (describing CarleCare HMO

[4] In addition, federal antitrust agencies have adopted enforcement policy statements specifically recognizing the potential benefits of physician-owned ventures for health-care consumers, particularly when the venture includes "significant financial incentives for its physician participants, to achieve specified cost-containment goals." *See* U.S. Dep't of Justice & Fed. Trade Comm'n, *Statement of Antitrust Enforcement Policy in Health Care* 69 (Aug. 1996) [available at <http://www.usdoj.gov>].

[5] Because the courts below decided this case solely on the pleadings, petitioners' factual recitation is limited to the complaint and its attachments.

as "a health maintenance organization organized as a product of [HAMP]"). In exchange, State Farm agreed that it and its employees would pay a fixed premium for the specified coverage. *Id.* Under the contract, HAMP thus assumed the financial risk for the provision of the benefits to State Farm employees. If the cost of services were to exceed the premiums received from State Farm and its employees, HAMP would lose money on the contract. Conversely, if the cost of services were less than those premiums, HAMP would make money on the contract.

The Carle Clinic Association is a professional medical corporation owned by its physician shareholders. In addition, the Carle Clinic Association is the sole shareholder both of HAMP and another petitioner, a management entity known as the Carle Health Insurance Management Co., Inc. ("CHIMCO"). App. 4a n.3. Accordingly, the physician shareholders of the Carle Clinic Association are, collectively, also the sole shareholders of HAMP and CHIMCO.

The Group Subscription Certificate agreed to by State Farm and HAMP describes the coverage provided to State Farm employees who receive health care arranged by the CarleCare HMO. Like many other HMOs and managed-care arrangements, the CarleCare HMO contains provisions designed to contain costs, and these provisions are recited in the Group Subscription Certificate. For example, the Certificate contains explicit exclusions and limitations, including requirements that participants and beneficiaries see CarleCare HMO physicians ("Carle physicians") or other participating providers, obtain only medically-necessary treatment, and use only CarleCare-approved facilities. See infra at 27-28.

Respondent Cynthia Herdrich's husband was employed by State Farm, and she received health-care coverage under the CarleCare HMO. In March 1992, Herdrich's appendix ruptured

as the result of allegedly inadequate medical treatment she received from petitioner Dr. Lori Pegram, a Carle physician. As a result, on October 21, 1992, Herdrich filed a complaint against Pegram and the Carle Clinic Association in the Circuit Court of McLean County, Illinois, alleging medical malpractice. On February 18, 1994, Herdrich amended her complaint to add two state-law counts (Count III, alleging a violation of the Illinois Consumer Fraud Act, and Count IV, alleging a violation of a contractual duty of good faith and fair dealing) against all petitioners.

Petitioners removed the case to federal court, asserting that the two new counts were preempted by ERISA. Petitioners further sought summary judgment on the new claims. The district court agreed that ERISA preempted both claims. The court further granted petitioners' motion for summary judgment on Count IV. It determined that, even if Count IV were re-pled as an ERISA claim, petitioners would be entitled to summary judgment, because Herdrich was seeking monetary relief, including extra-contractual damages, which ERISA does not allow. But the court granted Herdrich "leave to submit an amended Count III which clearly sets forth her basis for proceeding under ERISA, including the applicable civil enforcement provision." App. 79a-80a.

On September 1, 1995, Herdrich filed her amended Count III. That count is the subject of the decision at issue here. In amended Count III, Herdrich alleged that petitioners breached their fiduciary duty to plan participants and beneficiaries by implementing specified cost-containment measures. She alleged that the implementation of these measures resulted in cost savings to the CarleCare HMO, thereby permitting the CarleCare HMO to earn additional income. Some part of this profit, alleged the complaint, was paid to the Carle Clinic Association's owners, the CarleCare HMO physicians, in the form of year-end "supplemental medical

expense payments." Herdrich's claim therefore was that a health-care entity (here an HMO and its physician owners) breaches a fiduciary duty under ERISA when it earns additional income by implementing cost-containment measures, even if those cost-containment measures are a feature of the plan itself.[6]

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[6] Specifically, Herdrich alleged that:

> In breach of that [fiduciary] duty:
>
> a. CARLE owner/physicians are the officers and directors of HAMP and CHIMCO and receive a year-end distribution, based in large part upon, supplemental medical expense payments made to CARLE by HAMP and CHIMCO;
>
> b. Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:
>
> i. by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:
> (1) minimize the use of diagnostic tests;
> (2) minimize the use of facilities not owned by CARLE; and
> (3) minimize the use of emergency and non-emergency consultation and/or referrals to noncontracted physicians.
> ii. by administering disputed and non-routine health insurance claims and determining:
> (1) which claims are covered under the Plan and to what extent;
> (2) what the applicable standard of care is;
> (3) whether a course of treatment is experimental;
> (4) whether a course of treatment is

(continued...)

Petitioners filed a motion to dismiss amended Count III pursuant to Fed. R. Civ. P. 12(b)(6). A magistrate judge was assigned to hear the case by agreement of the parties. The Magistrate Judge recommended that petitioners' motion be granted, although he also recommended that Herdrich receive one last opportunity to plead an ERISA claim. App. 64a. Herdrich objected to the magistrate judge's recommendation pursuant to Fed. R. Civ. P. 72. On April 15, 1996, however, the district court adopted the magistrate judge's recommendation of dismissal. Herdrich chose not to re-plead.

After discovery, the remaining state-law counts of Herdrich's complaint went to trial in early December 1996. The jury returned a verdict in Herdrich's favor on these state-law medical malpractice claims and awarded her $35,000 in compensatory damages. App. 81a.

(b). Herdrich then appealed the district court's earlier dismissal of the ERISA claim in amended Count III of her complaint. In a split decision, the court of appeals reversed the judgment of dismissal. It determined that the bare allegation that petitioners implemented cost-containment measures which, if successful, would result in additional income for the HMO's owners (the Carle physicians) was sufficient to state an ERISA claim for breach of fiduciary duty.

Specifically, the court of appeals first held that petitioners "were plan fiduciaries due to their discretionary authority in deciding disputed claims." App. 14a. The court appeared (incorrectly) to believe that because petitioners were fiduciaries for this purpose, they could be characterized as

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[6] (...continued)

reasonable and customary; and
(5) whether a medical condition is an emergency. [Complaint ¶ 12 (App. 4a n.3).]

fiduciaries for all purposes. *Id.* The court then held that petitioners were "administer[ing]" and "manag[ing]" an ERISA plan, and thus acting as fiduciaries under ERISA section 3(21)(A), 29 U.S.C. § 1002(21)(A), when they established and implemented the cost-containment measures that were intended to produce additional income for the HMO and its owners.

In addition, the court concluded, Herdrich stated an ERISA claim for breach of fiduciary duty by alleging that petitioners implemented a mechanism that might create divided loyalties in providers of medical services:

> The Plan dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings. Because the physician/ administrators' year-end bonuses were based on the difference between total plan costs (*i.e.*, the costs of providing medical services) and revenues (*i.e.*, payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. [App. 18a-19a (emphasis omitted).]

In reaching its conclusion, the court detailed its fundamental view that cost-containment mechanisms substantially erode the quality of American health care and should be eliminated. *Id.* at 24a-32a. Finally, the court of appeals held that Herdrich had adequately pled damage to an ERISA plan as a result of the breach because she alleged that HAMP, which operated the CarleCare HMO, made annual payments to its owners -- the Carle physicians -- based on the extent to which cost-containment efforts were successful. *Id.* at 38a.

Judge Flaum dissented. He observed that the complaint simply "alleges that there is a conflict of interest built into the compensation structure of the health plan in question." App. 38a-39a. He accepted "the Majority's conclusion that, taking the allegations of the complaint as true, 'an incentive existed for [petitioners] to limit treatment and, in turn, HMO costs so as to ensure larger bonuses.'" *Id.* at 39a. But he disagreed with the majority's holding "that the mere existence of this asserted conflict, without more, gives rise to a cause of action for breach of fiduciary duty under ERISA." *Id.* As Judge Flaum explained, "many sponsors and beneficiaries of managed care plans view financial incentives as a desirable way of conserving the plan's assets by encouraging physicians to use resources more efficiently." *Id.* at 42a-43a. Thus, "merely alleging the existence of financial incentives to limit care cannot suffice to make out a claim of breach of fiduciary duty." *Id.* at 43a.

Petitioners sought rehearing and filed a suggestion for rehearing *en banc*. The court of appeals denied the petition on March 8, 1999. App. 48a-49a. Judge Easterbrook, joined by Chief Judge Posner and Judges Flaum and Wood, dissented from denial of rehearing *en banc*. The dissenting opinion concluded that the panel's decision was wrong and that it would have widespread and damaging repercussions. *Id.* at 49a-58a.

Judge Easterbrook first observed that the premise of the panel decision is that "HMOs and other managed-care systems are inferior to available alternatives." App. 51a. This premise, as he pointed out, is at a minimum open to question:

> "A[n HMO] offers, for a fixed fee, as much medical care as the patient needs. Providers using traditional fee-for-service methods, by contrast, change for each procedure. Each method creates an unfortunate incentive: a physician receiving a fee for each service has an incentive to run up the bill by furnishing unnecessary care, and an HMO has an incentive to skimp on care (once patients have signed up and paid) in order to save costs." [*Id.* (quoting *Anderson* v. *Humana, Inc.*, 24 F.3d 889, 890 (7th Cir. 1994)).]

Even assuming that managed care is inferior, however, Judge Easterbrook concluded that ERISA did not authorize the court to "prescribe its view of the best system" by labeling virtually all decisions implementing an HMO as fiduciary and, indeed, a fiduciary breach. *Id.*

For purposes of this case, Judge Easterbrook explained, petitioners are ERISA fiduciaries only "'to the extent'" that they have "'discretionary authority or discretionary responsibility *in the administration of [a] plan.*'" App. 52a (quoting 29 U.S.C. § 1002(21)(A) (emphasis supplied)). And while petitioners may be ERISA fiduciaries for some purposes, they were not acting as "fiduciaries" within the meaning of ERISA when they "establish[ed] one set of cost-saving incentives rather than another." *Id.* at 53a. It is possible, Judge Easterbrook acknowledged, "to read 'in the administration of [the] plan' broadly in order to catch all discretionary elements of the HMO structure," but the result of doing so would be "to wipe out HMOs and foreclose the possibility that plan sponsors will choose that structure." *Id.* (alteration in original). The panel thus had constructively held that ERISA health-care plans "have a fiduciary duty not to adopt HMO[s] or other managed-care options," because cost-containment incentives create a conflict of interest for the health-care provider. *Id.* at 54a.

Judge Easterbrook concluded that this result made little sense. The law is clear, for example, that plan sponsors may choose "to offer an HMO as a welfare benefit," but "a plan sponsor's right to adopt an HMO plan as a benefit would not be

worth anything if implementing the HMO itself violates ERISA." App. 54a. Moreover, he observed, "[m]ost medical care these days is furnished under ERISA plans. Most contemporary welfare benefit plans provide for managed care, through HMOs or other devices, at least as an option." *Id.* at 56a. Accordingly, he stated, "[b]y stretching the definition of 'fiduciary' under ERISA, the panel has effectively foreclosed a popular option for the delivery of medical care and taken the decision out of private hands, to which ERISA committed it." *Id.* at 54a.

Nor could the results of the panel's decision be cabined, "for the plan attacked in this case is an ordinary HMO":

> If Carle's setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations. Limiting care to specific locations, limiting referrals to specialists, and using capitation fees (with the possibility of profit from cost-reducing strategies), and reaping for the HMO's owners the benefits of reduced health-care expenditures, are the principal features of HMOs and "preferred provider organizations." [App. 56a-57a.]

Finally, Judge Easterbrook pointed out that even assuming that petitioners were acting as fiduciaries, the panel's holding -- that a bare allegation that an HMO employs cost-containment incentives states a claim for breach of fiduciary duty -- would have significant, damaging consequences: "[T]he panel's opinion puts all managed-care systems at risk and commits the court to a long (and I should think unhappy) course of distinguishing 'good' managed-care systems from 'bad' ones." App. 58a. These judgments, he stated, belong to

Congress or to plan sponsors and participants, and ERISA should not be used "to impress a different view of desirable medical care on employers and HMOs alike." *Id.*

This Court granted the petition for certiorari on September 28, 1999.

SUMMARY OF ARGUMENT

In the decision below, the court of appeals held that an HMO and its physicians act as fiduciaries under ERISA when those physicians receive financial incentives to provide medical care to the HMO's members in a cost-effective manner. The court further held that the bare allegation that an HMO has adopted such cost-containment features (as numerous health plans have) states a claim for breach of fiduciary duty under ERISA. Thus, the court of appeals effectively held that under ERISA, employers "have a fiduciary duty not to adopt HMO[s] or other managed-care options." App. 54a (Easterbrook, J., dissenting). ERISA imposes no such duty. The decision below should be reversed.

The court of appeals decided that petitioners were fiduciaries with respect to all discretionary decisions involved in the provision of health care to State Farm employees and their families. ERISA, however, imposes fiduciary obligations only "*to the extent*" that a person is exercising discretion in performing certain defined functions such as "administer[ing] or manag[ing]" an employee pension or welfare benefit "plan." 29 U.S.C. § 1002(21)(A) (emphasis added). When that person is engaged in *other* activities that involve the exercise of discretion, he or she is not acting as a fiduciary, even if the exercise of that discretion would substantially affect the plan. See *Hughes Aircraft Co.* v. *Jacobson*, 119 S. Ct. 755, 763 (1999); *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 890-91 (1996).

Petitioners were not engaged in any of the activities that trigger ERISA's fiduciary obligations when they implemented the cost-containment mechanism at issue here.

1. When it established its employee welfare plan, State Farm made plan-design decisions that called for the cost-containment measures, thus placing these measures outside of ERISA's fiduciary realm. Specifically, State Farm decided to "establish[]" and "maintain[]" its welfare benefit plan by purchasing memberships in the CarleCare HMO for its employees. See 29 U.S.C. § 1002(1). The sole plan benefit either established or maintained by the employer, therefore, was *membership* in the HMO, and only decisions about that specific benefit are fiduciary in nature. Accordingly, the CarleCare HMO was not making decisions about a benefit provided in an ERISA plan when it made internal, discretionary decisions in its provision of health care to members, including State Farm employees, and was not subject to ERISA's fiduciary standards. See Part I.A.1.

2. Even assuming, as petitioners do for the remainder of the brief, that the benefits provided by the State Farm plan are the particular medical services defined in the Group Subscription Certificate, State Farm's decision to provide health-care benefits through the CarleCare HMO was a plan-design decision not subject to ERISA's fiduciary standards. ERISA does not forbid an employer to select an HMO or other managed-care arrangement to provide health-care benefits to its employees. See *Hughes*, 119 S. Ct. at 763-64; *Lockheed*, 517 U.S. at 887. An HMO is, by definition, an entity that assumes "full financial risk on a prospective basis for the provision of basic health services," 42 U.S.C. § 300e(c)(2), and, as such, is financially motivated to contain costs. A plan sponsor's decision to provide health-care benefits through an HMO is therefore a plan-design decision that necessarily entails the implementation of cost-containment measures. And it cannot

be a fiduciary violation to *follow* the terms of the plan design, which is all that was alleged here. See Part I.A.2.

3. State Farm's decisions about plan design clearly rendered petitioners' implementation of the cost-containment mechanism at issue not subject to fiduciary duties. But even if they had not, petitioners' implementation of the mechanism nonetheless was not fiduciary in nature. As noted, an entity is a fiduciary only "to the extent" that it exercises discretionary authority in the "administration" or "management" of a plan. HMOs and other health-care providers make myriad discretionary decisions in arranging for health care for members, including its members who are participants in an ERISA plan. Many such judgments -- including the cost-containment mechanisms adopted -- have no direct impact on the benefits provided by an ERISA plan. Numerous HMO decisions -- *e.g.*, a decision to require pre-approval by the plan of hospital admissions -- might in a particular case be said to result in a reduction in the quality of benefits under a plan or affect a provider's judgment about when and where an enrollee should receive medical services. But it simply makes no sense to characterize as fiduciary all ordinary business judgments in any way connected with arranging health care under a plan.

Indeed, Herdrich's argument -- that the statutory definition of fiduciary conduct as discretionary decisions in the "administration" and "management" of an ERISA plan should be expanded to include decisions that have only an *indirect* impact on plan benefits -- cannot be squared with the structure of ERISA or this Court's precedent. There are numerous provisions in ERISA where Congress makes an explicit distinction between "direct" and "indirect" actions, including aspects of the definition of fiduciary that are *not* relied upon by Herdrich. See 29 U.S.C. § 1002(21)(A)(ii) (defining a fiduciary to include a person that "renders investment advice for a fee or other compensation, *direct or indirect*, with respect to any

moneys or other property of [an ERISA] plan"). See also *id.* §§ 1002(14), 1106(a), 1112. Congress pointedly did not characterize as fiduciary "direct or indirect" administration or management of an ERISA plan and, indeed, narrowed the common law scope of fiduciary responsibility under ERISA. This Court should reject Herdrich's invitation to read such language into the definition of fiduciary.

In addition, in the analogous area of ERISA preemption, this Court has held that state laws which have an *indirect* economic impact on ERISA plans and which may therefore *indirectly* affect plan administration do not "relate to" an ERISA plan and thus are not preempted. See *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815-16 (1997); *New York Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645, 659-60 (1995). If an act having an indirect economic influence on plan administration does not "relate to" an ERISA plan, *a fortiori*, a judgment that only potentially has an indirect economic influence on a plan benefit cannot be deemed to constitute "management" or "administration" of a plan.

Herdrich's expansive reading of "fiduciary" is flawed for several additional, independent reasons. It is well established that this Court will not "lightly" infer that "Congress has derogated state regulation, but instead ha[s] addressed claims of preemption with the starting presumption that Congress does not intend to supplant state law." *Travelers Insurance Co.*, 514 U.S. at 654. But if, as Herdrich maintains, medical and business judgments with only an indirect impact on plan benefits are deemed acts of plan administration or management and thus are fiduciary, then *any* state law claim based on such judgment necessarily "relate[s] to" an ERISA plan and is preempted. See 29 U.S.C. § 1144(a). Herdrich's reading of the act would also bring ERISA into square conflict with Congress' explicit authorization and approval of managed-

care arrangements. For example, in the HMO Act, Congress expressly authorized and approved the use of HMO arrangements for health-care delivery and preempted state laws designed to impede the emergence of HMOs. See 42 U.S.C. §§ 300e, 300e-10(a). Similarly, Congress has expressly encouraged the development of managed-care options in Medicare and Medicaid programs. See *id.* §§ 1395mm, 1396b(m). See Part I.B.

4. Even if petitioners' implementation of the cost-containment mechanism at issue were a fiduciary act, Herdrich's Complaint would fail to state a claim for breach of fiduciary duty. Herdrich asserts only that adoption of a cost-containment mechanism that gives an HMO or an HMO physician divided loyalties -- to patient/beneficiaries on the one hand and to financial gain on the other -- is inherently a beach of fiduciary duty. That is not the law under ERISA. To the contrary, ERISA expressly permits the same person or entity to act as a fiduciary in one context and in service of self-interest in another. See, *e.g.*, *Hughes*, 119 S. Ct. at 763; *Lockheed*, 517 U.S. at 890-91. Here the business judgments that help to shape the design of a health-care plan may be made with cost containment in mind, while benefit eligibility and delivery decisions must be made with fiduciary loyalty. Far from violating ERISA, this duality is contemplated by ERISA's definition of fiduciary. See Part II.

5. Finally, any doubt that Herdrich has failed to state a claim for breach of fiduciary duty is made plain by her failure to allege cognizable damage to an ERISA plan. According to Herdrich, "the plan" was injured by the year-end financial distribution from HAMP to its owners, the Carle physicians. This argument necessarily assumes that the CarleCare HMO included a trust fund for the benefit of plan members and that these financial distributions were part of the corpus of a trust intended to benefit the members of the CarleCare HMO. State

Farm, however, established no such trust and none is alleged. Rather, the benefit provided by the CarleCare HMO is "arrang[ing] for medical and hospital services and other health care services to the Subscriber in accordance with the Subscription Certificate." App. 93a. Thus, Herdrich's Complaint fails to allege any damage to an ERISA plan because the money paid to HAMP under its contract with State Farm was not part of any plan trust and the payment of some portion of that money to HAMP's owners did not deprive plan participants of any benefit promised by the CarleCare HMO. See Part III.

ARGUMENT

ERISA "comprehensively regulates employee pension and welfare plans." *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 732 (1985). An "employee welfare plan" is:

> any plan, fund or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits . . . . [29 U.S.C. § 1002(1).]

ERISA requires that employee welfare-benefit plans be established pursuant to a written instrument, *id.* § 1102(a)(1), and imposes a number of procedural standards concerning reporting, disclosure, and fiduciary responsibility, *id.* §§ 1021-31, 1101-14.[7] ERISA also preempts state laws "insofar as they may now or hereafter relate to any employee benefit plan." *Id.* § 1144(a). However, "[n]othing in ERISA requires employers

[7] Unlike pension plans, ERISA does not establish any "minimum participation, vesting, or funding requirements for welfare plans." *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 78 (1995).

to establish employee benefits plans. . . . [n]or does ERISA mandate what kind of benefit employers must provide if they chose to have such a plan." *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 887 (1996). See also *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983); *Alessi* v. *Raybestos-Manhattan, Inc.* 451 U.S. 504, 511 (1981).

It is ERISA's fiduciary responsibilities that are at issue in this case. Congress required plan fiduciaries to "discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104. Congress, however, recognized that it would be ultimately self-defeating to impose such fiduciary duties too broadly. Potentially "every business decision an employer makes can have an adverse impact on [an ERISA] plan" and businesses would naturally be extremely reluctant to offer such plans if doing so would require them to run their business for the sole benefit of the plan participants. *Varity Corp.* v. *Howe*, 516 U.S. 489, 527 (1996) (Thomas, J., dissenting). Thus, Congress made clear that "'ERISA does not require that "day-to-day corporate business transactions, which may have a collateral effect on prospective, contingent employee benefits, be performed solely in the interest of plan participants."'" *Adams* v. *Avondale Indus., Inc.*, 905 F.2d 943, 947 (6th Cir. 1990). Rather, "only when fulfilling certain defined functions, including the exercise of discretionary authority or control over plan management or administration, does a person become a fiduciary" under ERISA. *Lockheed*, 517 U.S. at 890 (citing 29 U.S.C. § 1002(21)(A)).[8]

[8] A person is also a fiduciary to the extent "he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so." 29 U.S.C. § 1002(21)(A). That provision is not at issue in this case.

By purchasing memberships in the CarleCare HMO for its employees, State Farm "established and maintained" an "employee welfare benefit plan" subject to ERISA. As set forth below, petitioners did not breach any fiduciary duty with respect to this ERISA plan when they implemented the cost-containment mechanism at issue here, and nothing in ERISA precludes the delivery of health-care benefits through such a managed-care arrangement.

I. AN HMO AND ITS PHYSICIANS DO NOT ACT AS FIDUCIARIES BY IMPLEMENTING COST-CONTAINMENT INCENTIVES.

The court of appeals held that petitioners were acting as fiduciaries when they implemented a cost-containment mechanism that financially rewards physicians for successfully containing costs while providing health care under the CarleCare HMO plan. Under ERISA,

> a person is a fiduciary with respect to a plan *to the extent* (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. [29 U.S.C. § 1002(21)(A) (emphasis supplied).]

A person is a fiduciary only "to the extent" that he or she is engaged in one of the defined activities. It follows therefore that when that person is engaged in other activities that involve

the exercise of discretion, he or she is not acting as a fiduciary, even though that exercise of discretion may substantially affect the plan. Thus, for example, an employer is not acting as a fiduciary when it selects a plan's terms or modifies or terminates the plan, even though that same employer is a fiduciary when administering the plan. See, *e.g.*, *Hughes Aircraft Co.* v. *Jacobson*, 119 S. Ct. 755, 763 (1999); *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 890 (1996).

The court of appeals appears to have believed that petitioners can be characterized as ERISA fiduciaries for all purposes if they are ERISA fiduciaries for any purpose. See, *e.g.*, App. 14a ("[w]e can reasonably infer that [petitioners] were plan fiduciaries due to their discretionary authority in deciding disputed claims"). That position is flatly contradicted by this Court's holdings in *Hughes* and *Lockheed*. This fundamental error appears to be the basis for the court of appeals' conclusion that petitioners have "discretionary authority or discretionary control respecting management of [the] plan" and "discretionary authority or discretionary responsibility in the administration of [the] plan." App. 12a. The critical question, however, is not whether petitioners are *ever* ERISA fiduciaries, but whether petitioners were acting as fiduciaries with respect to an ERISA plan when they implemented measures to contain costs and earn additional income for the HMO and its owners. They were not.

A. State Farm's Plan Design Decisions Rendered Petitioners' Implementation Of The Cost-Containment Mechanism At Issue Not Subject To Fiduciary Duties.

1. *Petitioners' Implementation of the Cost-Containment Mechanism At Issue Does Not Affect The Sole Benefit Offered Under the State Farm "Employee Welfare Plan."* In this case, the plan sponsor, State Farm, made the lawful choice to establish and maintain an ERISA plan that provides health-care benefits by purchasing memberships in the CarleCare HMO for its employees. As noted, an ERISA "plan" is *only* the "plan, fund, or program" that is "*established or maintained by [the] employer*." See 29 U.S.C. § 1002(1) (emphasis supplied). The sole benefit in the plan "established or maintained by [the] employer" here is *membership* in the CarleCare HMO. *Id.* Accordingly, the "plan" here consisted of (a) State Farm's provision of membership in the CarleCare HMO; (b) State Farm's designation of beneficiaries (*i.e.*, the group of employees entitled to receive that benefit); (c) State Farm's obligation partially to finance employees' membership in the CarleCare HMO; and (d) State Farm's procedure for employees to elect (or appeal the denial of) membership in the CarleCare HMO. See *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987) (explaining that a "plan" consists of intended benefits, intended beneficiaries, a source of financing, and a procedure to apply for and collect benefits).

After the State Farm plan was established, State Farm's discretionary decisions that related to individual employees' membership in the HMO became fiduciary in nature because they determined whether the employee would receive the benefit under State Farm's ERISA plan (*viz.*, the right to membership in the HMO). But the CarleCare HMO itself was not "established" and is not "maintained" by the "employer" (State Farm), and so the CarleCare HMO's internal decisions

about the arrangement or provision of health care to its members are not decisions about a benefit offered under an ERISA "employee welfare plan." As Judge Easterbrook put it:

> if . . . one conceives of the Carle Care HMO system as the benefit promised by the ERISA plan, then Carle is not a "fiduciary." It is just the supplier of medical care, like the surgeon [deciding how (if at all) to perform an operation]. . . . Herdrich does not allege that State Farm hired Carle to administer a medical plan that offers defined medical procedures as benefits; she alleges, rather, that the benefit State Farm offered is the CarleCare HMO system. . . . [T]o the extent there is uncertainty about the right way to characterize Carle's role, the court should prefer the characterization that preserves plan sponsors' (and participants') freedom of choice. That means treating the Carle HMO as the benefit, rather than treating Carle as the administrator of the ERISA plan. *If the HMO system is the benefit, then Carle is not acting as a fiduciary.* [App. 55a-56a (emphasis supplied).]

Because membership in the CarleCare HMO is the sole benefit under the State Farm "plan," the HMO's internal, discretionary decisions about the provision of health care for a member -- be it the HMO's decision that a particular treatment is experimental, a Carle physician's decision that a particular treatment is not warranted, or an HMO employee's decision that a member is not entitled to reimbursement for care outside of the HMO's service area -- do not constitute "administ[ration]" or "manage[ment]" of an "employee welfare plan" and are not subject to ERISA's fiduciary standards. Indeed, the CarleCare HMO's role with respect to its members

who are State Farm employees differs not one iota from its role with respect to those who are not. The HMO is arranging health care, not making fiduciary judgments with respect to a benefit under an ERISA plan. For this reason alone, the court of appeals' decision that petitioners were acting as fiduciaries should be reversed.

2. *The Cost-Containment Mechanism At Issue Is A Matter of Plan Design Not Subject to ERISA's Fiduciary Standards.* For the rest of the brief, petitioners assume that the benefits under the State Farm plan are the particular medical services specified in the Group Subscription Certificate. Even if that is so, State Farm's decision to arrange health-care benefits through the CarleCare HMO was a plan-design decision not subject to ERISA's fiduciary standards. See *Lockheed*, 517 U.S. at 890-91; *Hughes*, 119 S. Ct. at 763-64. Equally clearly then, neither State Farm nor petitioners were acting as fiduciaries when they agreed to provide benefits through a plan which expressly included cost-containment measures designed to reduce the HMO's costs and increase its earnings.

The plan-design decision to provide benefits through an HMO is significant here. The plan benefits at issue are not simply the health-care services enumerated in the Group Subscription Certificate divorced from the exclusions and the limitations also set forth therein. Under the State Farm plan, Herdrich was entitled to the health-care coverage provided by the Carle Clinic *HMO*. See Group Subscription Certificate (App. 93a) ("CarleCare HMO agrees to arrange for medical and hospital services and other health care services to the Subscriber in accordance with the Subscription Certificate"). An HMO is, by definition, an entity that assumes "full financial risk on a prospective basis for the provision of basic health services, except that a[n] HMO may . . . make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume

all or part of the financial risk . . . for the provision of basic health services. . . ." 42 U.S.C. § 300e(c)(2). The chief attraction of such entities, according to Congress, is that they are financially motivated to contain costs. See S. Rep. No. 93-129 (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, 3047. A plan sponsor's decision to provide health-care benefits through an HMO is therefore a plan-design decision which necessarily entails the implementation of cost-containment measures designed to reduce costs and increase earnings for the HMO and its owners.

That is precisely the decision State Farm made here. It entered into an agreement which provided that State Farm employees would receive health-care benefits arranged by the CarleCare HMO. The CarleCare HMO bore the financial risk arising out of the arrangement of health-care services to State Farm employees and their families who became members. It therefore implemented measures which encouraged physicians and other individual providers to contain costs, which, when successful, resulted in additional net income for the HMO and its owners. Herdrich's claim that petitioners breached their fiduciary duty by doing so is, at bottom, nothing more than a claim that it is a fiduciary breach to provide health-care benefits through an HMO.

It is evident on the face of the principal plan document here -- the Group Subscription Certificate -- that the CarleCare HMO had cost-containment measures in place. Indeed, each cost-containment measure which Herdrich cited as part of the fiduciary breach is expressly recited in the Group Subscription Certificate. Specifically, Herdrich alleged a breach of fiduciary duty in HAMP's and CHIMCO's agreement with the Carle Clinic Association to "minimize the use of diagnostic tests," minimize the use of non-CarleCare HMO facilities, and minimize the use of consultations and referrals to "non-contracted physicians." Complaint ¶ 12(b)(I)(1) (App. 86a).

The Group Subscription Certificate establishing Herdrich's health-care benefits itself stated that "[d]iagnostic and treatment services by non-CarleCare Physicians were provided only when referred by the Primary Care Physician," and required "prior written authorization from the CarleCare Medical Director" except in emergencies, as defined elsewhere in the Group Subscription Certificate. Section 7.2 (App. 111a). It further provided that, except in defined emergencies, "[c]are by Physicians, other than CarleCare Physicians or Providers, or in hospitals not associated with CarleCare" was "NOT covered by CarleCare." Section 8.1 (App. 118a). Similarly, the Group Subscription Certificate required that "X-ray and laboratory tests and services" be approved by the Medical Policy Committee and explained that they were "covered [only] when Medically Necessary" and "obtained at an approved CarleCare facility." Section 6.5 (App. 103a).

Herdrich also alleged that HAMP sought to reduce costs by determining the CarleCare HMO's coverage, the CarleCare HMO's applicable standard of care, which proposed treatments were experimental, whether certain treatments were reasonable and customary, and whether an emergency existed. Again, the General Subscription Certificate explicitly indicated that these common place cost-containment measures were in effect. See Section 6 (App. 102a) (defining "service schedule" and explaining that services were provided "subject to the Limitations and Exclusions . . . and in accordance with accepted medical and surgical practices and standards approved by the Medical Policy Committee of CarleCare in conjunction with the Primary Care Physician"); Section 1.14 (App. 95a) (defining "[m]edically [n]ecessary"); Section 6.18 (App. 107a) (defining "[e]mergency [m]edical [c]are"); Section 8 (App. 118a) (defining "[e]xclusions," including the exclusion for services not medically necessary).

The cost-containment measures Herdrich cited in support of her claim for fiduciary breach thus were, in terms, elements of the CarleCare HMO's design. Herdrich's only further allegations were (a) that the owners of the HMO had a financial incentive to contain costs in order to earn additional income, and (b) that the owners of the CarleCare HMO were the CarleCare HMO physicians. Neither of these allegations removes her claim from the realm of plan design.

With respect to the first, a decision to utilize an HMO or other managed-care organization is a plan-design decision to accept a care provider motivated to contain costs in order to earn additional income. See 42 U.S.C. § 300e(c); *supra* at 4-5. A primary goal and a necessary consequence of effective cost containment is earnings for the HMO:

> *If [petitioners'] setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations.* Limiting care to specific locations, limiting referrals to specialists, and using capitation fees (with the possibility of profit from cost-reducing strategies), and reaping for the HMO's owners the benefits of reduced health-care expenditures, are the principal features of HMOs and "preferred provider organizations." [App. 57a (emphasis supplied).]

With respect to the second, it makes no "legal (or practical) difference" that the CarleCare HMO is owned by its physicians. App. 57a. All HMO owners have a financial incentive to contain costs and to earn additional income. Physician owners are not more likely than corporations or other HMO owners to pursue cost containment at the expense of patient welfare. Indeed, physicians' decisions concerning

patients are governed by professional medical codes, see American Medical Ass'n, *Code of Medical Ethics* (1998-99), and the law of medical malpractice, so physician owners of HMOs are substantially *less* likely than corporate owners of HMOs to make medical and business judgments solely on the basis of their financial interest. See also E. Hirshfeld, *The Case for Physician Direction in Health Plans*, 3 Annals of Health Law 81, 92 (1994). Moreover, as Judge Easterbrook pointed out, the effect of any particular medical decision on the income of an HMO owner, including a physician owner, is "minuscule." App. 57a.

In sum, ERISA does not forbid an employer to select an HMO or other managed-care arrangement to provide health-care benefits to its employees. State Farm, the plan sponsor, decided to provide health-care benefits to its employees through the CarleCare HMO. The Group Subscription Certificate on its face contained all of the measures which Herdrich cited as fiduciary breaches in her Complaint -- measures plainly designed to encourage cost containment and to increase the earnings of the HMO and its owners. In addition, and of critical importance here, that consequence was inherent in the decision to provide benefits through an HMO. It simply cannot be a fiduciary violation to *follow* the terms of a plan which is all that is alleged here. See also 29 U.S.C. § 1104(a)(1)(D) (requiring a fiduciary to act "in accordance with the documents and instruments governing the plan"). Herdrich's claim that petitioners breached their fiduciary duty by implementing cost-containment measures in order to earn additional income for the HMO thus seeks to apply ERISA's fiduciary standards to a plan-design decision and, for that reason alone, should be dismissed.

B. Even Assuming That Implementation Of Financial Incentives For Cost-Containment Is Not A Plan Design Decision, Petitioners' Implementation Of Such Incentives Is Not Fiduciary In Nature.

1. In her amended Count III, Herdrich did not claim that she has been denied a plan benefit as defined by ERISA. Such an allegation plainly would state a claim under ERISA. Instead, she asserted that the CarleCare HMO had in place a practice or policy (the cost-containment measures and the year-end financial distributions to CarleCare HMO physicians) that gave CarleCare HMO administrators and physicians a financial incentive to limit care. She further claimed that this practice or policy might indirectly result in incorrect decisions about plan benefits. She maintained that HMOs are "administer[ing]" or "manag[ing]" an ERISA "plan" when they implement business and medical policies, practices, and judgments that have an *indirect effect* on plan benefits. Finally, she alleged, the implementation of the policy or practice at issue here was a *fiduciary breach* because it *might indirectly affect* benefits by inducing HMO administrators and physicians not to provide treatment or to provide lower-quality treatment.

As noted several times, ERISA's definition of "fiduciary" provides that institutions and individuals are fiduciaries "to the extent" they have discretionary authority in the "management" or "administration of [an ERISA] plan." 29 U.S.C. §1002(21)(A). This definition has not previously been, and should not now be, interpreted so expansively as to embrace any act or decision by a health-care provider that may indirectly affect benefits provided under an ERISA plan. Specifically here, petitioners' implementation of financial incentives for physicians to contain the costs of providing health-care benefits under a plan was not a fiduciary act,

because it did not involve "administration" or "management" of an ERISA "plan."

State Farm established an ERISA plan for its employees by purchasing for them memberships in the CarleCare HMO. The HMO was not itself an ERISA plan, but it played important roles in connection with the plan. If the plan benefits are the particular medical services in the Group Subscription Certificate, then the CarleCare HMO was acting as the administrator of an ERISA plan when it took action that directly affected participants' entitlement to benefits under the plan (*e.g.*, when a CarleCare HMO administrator denied or granted a claim for benefits under the plan). But see Part I.A.1., *supra*. In addition, the HMO arranged for medical care for its subscribers, including ERISA plan participants. When performing this role, the HMO made numerous business and medical decisions that might indirectly have affected plan benefits.[9]

An HMO is a plan fiduciary within the meaning of ERISA only when it is administering the plan, *i.e.*, only when making decisions and taking actions which directly affect an individual participant's entitlement to plan benefits. It is not administering the plan -- and thus is not a fiduciary -- when in the course of providing or arranging for medical care, it makes business and medical decisions which have only an indirect effect on plan benefits. If the concept of plan administration and management were expanded to embrace all decisions which indirectly affect benefits, virtually all decisions affecting an ERISA plan would implicate fiduciary responsibilities, would be regulated by federal law, and could be litigated in federal court. Cf. *New York Conference of Blue Cross & Blue Shield Plans* v.

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[9] An HMO is also the insurer of the health care benefits promised by the employer. Congress expressly preserved most state regulation of the business of insurance in section 514(b)(2) of ERISA, 29 U.S.C. § 1144(b)(2).

Travelers Insurance Co., 514 U.S. 645, 655 (1995) ("[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere'") (quoting H. James, *Roderick Hudson*, xli (New York ed., World's Classics 1980) (second alteration in original)).

Most plainly, under Herdrich's theory, all discretionary medical judgments -- from the medical policy judgment that certain treatments are experimental to individual physician judgments involving the need for treatment and its substance and timing -- would constitute acts of plan administration and thus fiduciary judgments subject to ERISA. As a result, all of an HMO's medical professionals, from its Medical Policy Committee to individual physicians, would be subject to ERISA's fiduciary standards (and not state law) each time they made a discretionary decision which indirectly affected health-care benefits.

In addition, health-care institutions and professionals who provide benefits under ERISA plans make numerous business policies and judgments that may indirectly affect health-care benefits. For example, all businesses, including health-care providers, seek to control costs; virtually any cost-saving decision may indirectly affect benefits. When a managed-care organization decides to pay hospitals a set fee per in-patient admission, regardless of the patient's length of stay, that arrangement financially rewards the hospital for treating a large number of patients and discharging them as quickly as possible. HMOs may restrict care, refuse to cover certain kinds of therapies, discipline or fail to promote physicians and other providers who fail to contain costs, or financially reward physicians and other health-care providers for containing costs. Such decisions inherently involve a careful balancing of business and clinical considerations and may indirectly affect benefits.

On Herdrich's and the court of appeals' theory, all such decisions are fiduciary in nature and subject to ERISA, and thus courts must decide whether they have been made with an "eye single" to the interests of participants. See *Donovan* v. *Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982) (Friendly, J.). This outcome is entirely inconsistent with the structure of ERISA. In ERISA, Congress narrowed the scope of fiduciary obligations found in the common law of trusts. For example, ERISA trustees, unlike common law trustees, may possess dual loyalties and, indeed, may act in furtherance of their conflicting interests outside of the fiduciary realm. See 29 U.S.C. §1002(21)(A) (a person is an ERISA fiduciary only "to the extent" that he or she is engaged in certain types of acts); *Varity Corp.* v. *Howe*, 516 U.S. 489, 498 (1996) (an ERISA trustee may have and act on dual loyalties). But if the fiduciary realm expands beyond decisions that directly affect benefits to embrace all decisions that indirectly affect benefits, most business and medical judgments made in providing health-care benefits under an ERISA plan will be deemed fiduciary, and Congress' deliberate attempt to limit the area of application of ERISA's fiduciary standards will be frustrated. Cf. *id.* at 539 (Thomas, J., dissenting) (explaining that an employer is not acting as a fiduciary simply "because an ordinary business decision turn[ed] out to have an adverse impact on the plan").[10]

Herdrich's argument -- that the statutory definition of fiduciary conduct as discretionary decisions in the "administration" and "management" of an ERISA plan should be expanded to include decisions that have only an indirect

[10] Perhaps the courts could somehow limit the expansive reach of Herdrich's interpretation of "fiduciary," by considering how substantial an indirect effect on plan benefits or administration is required before a business or medical judgment is deemed fiduciary. Under such a fact-specific test for fiduciary status, however, the extent of "fiduciary" responsibility would become even more ill-defined.

impact on plan benefits -- is inconsistent with another important aspect of ERISA's structure. There are numerous provisions in ERISA where Congress makes an explicit distinction between "direct" and "indirect" actions. Indeed, in the definition of fiduciary, Congress states that a party that "renders investment advice for a fee or other compensation, *direct or indirect*, with respect to any moneys or other property of [an ERISA] plan" is a fiduciary. 29 U.S.C. § 1002(21)(A)(ii) (emphasis added). See also *id.* § 1002(14) (making certain "direct or indirect" owners "parties in interest"); *id.* § 1106(a) (making certain "direct or indirect" transactions illegal); *id.* § 1112 (prohibiting ERISA fiduciaries from procuring a bond from parties that have "direct or indirect" financial relationships with the plan). Congress pointedly did not characterize as fiduciary "direct or indirect" administration or management of an ERISA plan, and this Court should reject Herdrich's invitation to read such language into the definition of fiduciary.

In the closely analogous area of ERISA preemption, this Court has twice recently held that state laws which have merely an *indirect* economic impact on ERISA plans and which may therefore *indirectly* affect plan administration do not "relate to" an ERISA plan and thus are not preempted. In *Travelers Insurance Co.*, this Court explained that it was unwilling to preempt a state law which had only an "indirect economic influence" on plan administrators, relying on the State's strong and traditional interest in regulating the provision of health care. See 514 U.S. at 659 ("[a]n indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself"); *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815-16 (1997) (a state law which "increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans," but nonetheless

does not "'relate to'" an ERISA plan).[11] If an act having an indirect economic influence on plan administration does not "relate to" an ERISA plan, it follows that a judgment that only potentially has an indirect economic influence on a plan benefit should not be deemed to constitute "management" or "administration" of a plan.

In this case, participants and beneficiaries covered by the State Farm plan were entitled to the health-care benefits set forth in the Group Subscription Certificate. Herdrich did not -- and could not -- allege that petitioners had in place a cost-saving mechanism, policy or practice that altered the terms of the plan or directly deprived a participant of benefits provided by the plan. (Quite to the contrary, as the amended complaint and the attached Group Subscription Certificate reflect, *the cost-saving features that Herdrich objected to are embodied in the terms of the plan itself.*) Accordingly, the cost-containment mechanism of which Herdrich complained was the product of a business and medical decision, not a decision about a plan benefit. And, although that decision may potentially have had an indirect effect on the provision of benefits (the health-care services provided by the CarleCare HMO), petitioners were not engaged in plan administration or management when they made it.

2. Herdrich's broad interpretation of ERISA's definition of "fiduciary" is inconsistent with the Act in another way: It would substantially expand ERISA's already significant preemptive effect on state law. As this Court has stated, nothing in ERISA or its legislative history suggests any express

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[11] *Cf. California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997) (holding that California's prevailing wage law is not preempted by ERISA); *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 838-41(1988) (explaining that a law operating as merely an indirect source of economic influence on administrative decisions should not suffice to trigger preemption).

congressional desire to preempt general state regulation of the provision of health care. Hence, this Court has "never assumed lightly that Congress has derogated state regulation, but instead ha[s] addressed claims of preemption with the starting presumption that Congress does not intend to supplant state law." *Travelers Insurance Co.*, 514 U.S. at 654 (citing *Maryland* v. *Louisiana*, 451 U.S. 725, 746 (1981)). Indeed, where it is said that federal law displaces "state action in fields of traditional state regulation, [the Court has] worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *Id.* at 655 (citation omitted) (quoting *Rice* v. *Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

Indeed, this Court has already explained that "nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 661 (citing *Hillsborough County* v. *Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985)). Herdrich's proposed interpretation of "fiduciary," however, would broadly preempt state law in this area of traditional local concern. ERISA preempts any state law that "relate[s] to" an ERISA plan. See 29 U.S.C. § 1144(a). The more expansively ERISA defines "fiduciary," the more conduct traditionally regulated by the state will be preempted by and subject to ERISA. If medical and business judgments with an indirect impact on plan benefits are deemed acts of plan administration or management and thus fiduciary under federal law, then any state law tort claim, including a medical malpractice claim, based on such a judgment necessarily "relate[s] to" an ERISA plan. On Herdrich's theory, most medical or business judgments are acts of plan

administration or management, and any state law regulation of these judgments is preempted by ERISA.[12]

Absent some express indication that Congress intended such preemption to occur, this Court has refused to interpret ERISA to deprive the States of their traditional power to regulate the provision of health care. This Court has carefully cabined the definition of the phrase "relate to" to prevent such an impingement; for similar reasons, the definition of "administration" and "management" ought likewise to be confined. Indeed, Herdrich's broad construction would result in virtually the same sweeping preemptive effect on state laws affecting health care that this Court disapproved in *Travelers Insurance Co.* For this reason, too, ERISA's definition of fiduciary should not be interpreted to sweep in business and medical policies, practices, and judgments that only potentially and indirectly affect a participant's right to receive a benefit under an ERISA plan, such as an HMO's decision to implement a particular cost-containment mechanism.

3. Herdrich's expansive reading of ERISA is also wrong because it unnecessarily brings ERISA into conflict with Congress' explicit authorization and approval of managed-care

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[12] In an effort to avoid such preemption, the courts of appeals struggle to distinguish plan administration from the arrangement or provision of medical care. There are a number of court of appeals decisions addressing whether discretionary medical policies, practices, and judgments are acts of plan administration. *See*, e.g., *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350, 352-53 (3d Cir. 1995); *Pacificare, Inc.* v. *Burrage*, 59 F.3d 151, 154 (10th Cir. 1995); *Lupo* v. *Human Affairs Int'l, Inc.*, 28 F.3d 269, 272-73 (2d Cir. 1994); *Corcoran* v. *United HealthCare, Inc.*, 965 F.2d 1321, 1329 (5th Cir. 1992). There appears to be general agreement that only allegations that a participant has been denied a plan benefit should be considered preempted under ERISA, but the courts are plainly divided about how to determine when a claim addressed to medical care is a claim that a plan benefit has been denied (and thus preempted by 29 U.S.C. § 1132(a)) or a claim that "relate[s] to" a plan (and thus preempted by 29 U.S.C. § 1144).

arrangements. Her interpretation of ERISA's definition of "fiduciary" would derail virtually any attempt to implement cost-containment strategies. If business and medical policies, practices, and judgments which might indirectly affect benefits under an ERISA plan are fiduciary, then a fiduciary breach occurs virtually any time a health-care provider implements a cost-containment mechanism. See *supra* at 26-27.[13] The legislative history of ERISA contains no suggestion that Congress intended to preclude managed-care arrangements, and ERISA should not be interpreted to have that consequence. See ERISA section 514(d), 29 U.S.C. § 1144(d) ("Nothing in this subchapter [ERISA] shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States [except where expressly indicated], or any rule or regulation issued under any such law.").

As described above, Congress passed the HMO Act in 1972 to encourage the growth of HMOs. By statutory definition, HMOs assume the financial risk of providing health care and are expressly authorized to place some of that financial risk on physicians and other health-care professionals providing services. See *supra* at 4-5. Congress has also encouraged the implementation of managed-care options in the federal

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[13] As Judge Easterbrook stated:

> [W]hy should courts do this? In order to wipe out HMOs and foreclose the possibility that plan sponsors will choose that structure (or that participants will select it from among options the plan offers)? The panel's opinion sounds very much like this is the objective: its lengthy condemnation of managed care, 154 F. 3d 373-79, otherwise is hard to understand. [App. 53a.]

Medicare and Medicaid programs. See 42 U.S.C. §§ 1395mm, 1396b(m), 1395w-25.[14]

These initiatives demonstrate a congressional commitment to development of alternative health-care delivery systems and to the direct financial participation of physicians and other health-care providers in those systems. More directly to the point, they provide an important reason that federal courts should not expand ERISA's definition of "fiduciary" to make unlawful the type of health-care organization that Congress has promoted as an alternative to traditional fee-for-service arrangements. See *Morton* v. *Mancari*, 417 U.S. 535, 551 (1974) ("when two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective").

4. Finally, extant federal and state regulation -- and the ever-increasing public and legislative interest in the issues raised by managed care -- demonstrate that there is no need artificially to expand ERISA in order to address these issues. As set forth *supra* at 4-5, Congress has already enacted general legislation governing managed care, as well as legislation addressed to managed-care issues in the setting of federal programs. Additional federal legislation is actively being contemplated. In addition, numerous States have enacted HMO laws, including those specifically addressing managed-care arrangements that may have an impact on the quality of care.[15] This type of state

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[14] *See also* 42 C.F.R. § 417.479 (addressing financial incentives in the Medicare and Medicaid contexts).

[15] *See, e.g.*, Me. Rev. Stat. Ann. tit. 24-A, §§ 2671-2676 (Maine); N.Y. Pub. Health Law §§ 4400-4413 (New York); N.D. Cent. Code §§ 26.1-18.1-01 to -25 (North Dakota); Pa. Stat. Ann. tit. 40, §§ 1551-1568 (Pennsylvania); Tex. Civ. Prac. & Rem. Code Ann. §§ 88.001-.003 (Texas) (upheld in part, *Corporate Health Insurance Inc.* v. *Texas Dep't of Insurance*, 12 F. Supp. (continued...)

regulation has not been deemed preempted except where the court concludes that it has mandated particular employee-benefit structures or specific aspects of plan administration.[16] Indeed, state regulation of certain cost-containment mechanisms, such as capitation agreements and other financial arrangements between HMOs and providers, may be expressly saved from ERISA preemption as laws governing the business of "insurance." 29 U.S.C. § 1144(b)(2). See also *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 741-47 (1985); Carol L. O'Brien, *Direct Contracting: Potential Legal and Regulatory Barriers*, 79 Minn. Med. 21, 23 (1996) (discussing National Association of Insurance Commissioners, Draft White Paper on the Regulation of Risk-Bearing Entities (Sept. 25, 1996)).

In addition, many courts have addressed state-law claims that HMOs or other managed-care providers are liable for injuries resulting from policies, practices, or physician judgments related to cost containment. See generally William E. Milks, J.D., Annotation, *Liability of Health Maintenance Organizations (HMOs) for Negligence of Member Physicians*, 51 A.L.R. 5th 271 (1997) (collecting cases holding HMOs accountable under a variety of legal theories, including vicarious liability based on apparent authority, respondeat superior, direct corporate negligence, breach of contract and breach of

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[15] (...continued)
2d 597 (S.D. Tx. 1998)). *See also generally*, U.S. Dep't of Health & Human Servs., *State Regulatory Experience with Provider-Sponsored Organizations* (1997).

[16] *See Washington Physicians Serv. Ass'n* v. *Gregoire*, 147 F.3d 1039, 1045 (9th Cir. 1998), *cert. denied*, 119 S. Ct. 1033 (1999); *Corporate Health Insurance, Inc.* v. *Texas Dep't of Insurance*, 12 F. Supp. 2d 597, 620-21 (S.D. Tx. 1998); *American Drug Stores, Inc.* v. *Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60, 69 (D. Mass. 1997); *Physicians Health Plan, Inc.* v. *Citizens Insurance Co. of Am.*, 673 F. Supp. 903, 905 (W.D. Mich. 1987).

warranty). See, *e.g.*, *Pacificare, Inc.* v. *Burrage*, 59 F.3d 151, 155 (10th Cir. 1995) (claims challenging the quality of the benefit provided are not preempted); *Ouelette* v. *Christ Hosp.*, 942 F. Supp. 1160, 1165 (S.D. Ohio 1996) (holding that negligence claim against HMO arising out of policy furthering cost containment is not preempted); *Maltz* v. *Aetna Health Plans*, 152 F.3d 919 (2d Cir. 1998) (table) (holding that allegations about reduction in the quality of care are properly brought under state law); *Petrovich* v. *Share Health Plan., Inc.*, No. 85-726 (Ill. filed Sept. 30, 1999) (same); *Pappas* v. *Asbel*, 724 A.2d 889, 893 (Pa. 1998) (same), *petition for cert. filed*, 67 USLW 3717 (U.S. May 13, 1999) (No. 98-1836). See generally *McEvoy* v. *Group Health Coop.*, 570 N.W.2d 397 (Wis. 1997) (same); *Wilson* v. *Blue Cross*, 271 Cal. Rptr. 876 (Cal. Ct. App. 1990) (same).

There is no dearth of regulatory activity in this area and thus no vacuum that ERISA should expand to fill. To the contrary, the extant and prospective federal and state regulation of managed care indicates that the Congress did not intend ERISA to preclude either managed care or legislative regulation of managed care.

* * * *

In sum, numerous medical and business judgments made by an HMO or its physicians may have some indirect effect on benefits. But such judgments do not alter a plan or deprive any participant or beneficiary of plan benefits. They therefore are *not* exercises of discretion in the "management" or "administration" of an ERISA "plan" resulting in fiduciary liability, but rather "exercise[s] of managerial discretion in the administration of [an HMO's] business." App. 53a (Easterbrook, J., dissenting). Petitioners thus were not acting as fiduciaries when they implemented the cost-containment mechanism at issue here.

II. AN ALLEGATION THAT AN HMO FINANCIALLY REWARDS ITS OWNER PHYSICIANS FOR SUCCESSFUL COST-CONTAINMENT DOES NOT STATE A CLAIM FOR BREACH OF FIDUCIARY DUTY.

In amended Count III of her complaint, Herdrich alleges that the same administrators:

> vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who become eligible to receive year-end bonuses as a result of cost-savings. Because the physician/administrators' year-end bonuses were based on the difference between total plan costs (*i.e.*, the costs of providing medical services) and revenues (*i.e.*, payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. [App. 19a (emphasis omitted).]

The court of appeals held that these allegations state a claim for fiduciary breach. It observed that under petitioners' cost-containment mechanism, the individuals making fiduciary judgments (HMO administrators and physicians) have a financial incentive not to make appropriate decisions about plan benefits and thus operate under a conflict of interest. The existence of these financial incentives, the court stated, breaches petitioners' fiduciary duty to plan participants and beneficiaries.

The lower court's decision is based on a fundamental misunderstanding of the structure of ERISA. Its conclusion that petitioners' cost-containment mechanism is unlawful simply because it creates divided loyalties in administrators and

physicians who make fiduciary decisions is wrong. As stated *supra* at 34, ERISA specifically authorizes ERISA fiduciaries to have dual loyalties, *i.e.*, interests which conflict with those of plan participants and beneficiaries. See, *e.g.*, 29 U.S.C. § 1108(c)(3) (authorizing an employer to act as both plan sponsor and plan administrator). Indeed, ERISA defines an institution or individual as a fiduciary only "to the extent that" that institution or individual is making discretionary judgments under the plan, so that those with interests that conflict with the interests of plan participants (such as employers and employer representatives) may nonetheless administer ERISA plans. *Id.* § 1002(21)(A). This Court has often contrasted ERISA's authorization of dual loyalties with the "common law of trusts [which] prohibits fiduciaries from holding positions that create [a] conflict of interest with trust beneficiaries." See *Varity Corp.* v. *Howe*, 516 U.S. 489, 498 (1996) (citing *NLRB* v. *Amax Coal Co.*, 453 U.S. 322, 329-30 (1981)).

Congress thus has made clear, and this Court has confirmed, that a person who is an ERISA fiduciary may *have* conflicting loyalties. In fact, when making decisions that are not themselves fiduciary, an ERISA fiduciary may also *act* on those conflicting loyalties without breaching any fiduciary obligation under ERISA. See *Hughes Aircraft Co.* v. *Jacobson*, 119 S. Ct. 755, 763 (1999); *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 890 (1996).

Under ERISA, for example, an employer that is also a plan sponsor decides what health benefits to offer and makes plan design, modification, and amendment decisions unencumbered by fiduciary obligations under ERISA; in so doing, the employer may keep its eye firmly fixed on its bottom line and place whatever limits it chooses on the health care benefits provided by the plan. That same employer, when acting as plan administrator, must make decisions about the specific distribution of benefits under the plan as a fiduciary with an "eye

single" to the interests of the patient/beneficiaries. See, *e.g.*, *Hughes*, 119 S. Ct. at 763 ("an employer's decision to amend a pension plan concerns the composition or design of the plan itself and does not implicate the employer's fiduciary duties which consist of such actions as the administration of the plan's assets").

Hughes and *Lockheed* are illustrations of the general point that individuals who act as ERISA fiduciaries when making plan-benefit decisions do not breach their duty to plan participants simply because they simultaneously have a financial interest in denying benefits to plan participants. Indeed, these cases go further. They demonstrate that ERISA allows individuals who are ERISA fiduciaries not only to have interests which conflict with those of plan participants, but also to *act* on those conflicting interests when making decisions that are not fiduciary in nature.

Analogously here, an employer may decide to provide health benefits through an HMO. The HMO and its physician owners employ cost-containment mechanisms and make other business and medical determinations with an eye to containing the HMO's costs and increasing its income. Assuming that the plan benefits are the specific medical services provided by the HMO, but see Part I.A.1., *supra*, that same HMO and its physicians must make decisions about plan benefits with an "eye single" to the interests of the patient/beneficiaries. The existence of a conflicting financial interest (in increasing the HMO's income), by itself, does not state a claim for breach of fiduciary duty. Cf. App. 58a (Easterbrook, J., dissenting) ("Lawyers owe fiduciary duties to their clients. Can it be that the incentive given by the partnership's reward structure to substitute the services of associates for those of partners creates a conflict of interest that invariably violates those duties? If the answer is 'no' for law firms (and that must be the right answer), it is 'no' for HMOs, in stock or partnership form").

The decision below is thus inconsistent with the text of ERISA and with this Court's decisions. And, like the holding that an HMO is acting as a fiduciary when it makes decisions that indirectly affect benefits, it also nullifies *Congress*' decision to authorize and nurture HMOs. See *supra* at 4-5. The conflict of interest cited by the court of appeals is present virtually every time that an HMO or other managed-care organization makes a medical or business decision. As described *supra* at 27, every provider which bears the financial risk of providing health care has a substantial incentive to contain costs. By definition, then, there is a tension between such a provider's duty to patients and its financial interest. Thus, a determination that such a conflict breaches a fiduciary duty under ERISA is a determination that HMOs and other managed-care arrangements may not provide benefits under an ERISA plan. Reasonable people can and do differ about the relative efficacy and benefits of fee-for-service and managed-care arrangements for health-care delivery, but Congress' decision to authorize managed-care arrangements should not be overruled by an unduly broad interpretation of ERISA.[17]

Ironically, fee-for-service medicine also creates a conflict between the financial interest of the provider and the patient's interests, because in that setting, the health-care provider's financial interest is to prescribe the most

[17] *See, e.g., Weiss* v. *CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 753 (S.D.N.Y. 1997) ("Weiss' contention that CIGNA's compensation package [for physicians] facially violates ERISA simply because it deprives her of her right to receive 'medical opinions and referrals unsullied by mixed motives,'. . . is tantamount to a claim that risk-sharing arrangements in managed care are inherently illegal, a position that is refuted by federal and New York law. *See* 42 U.S.C. § 300(e)(2); 42 C.F.R. § 417.103(b); N.Y. Pub. Health Law § 4403(1)(c). Moreover, plaintiff's concern about the soundness of managed care policy is best suited for resolution by branches of government other than the judiciary."). *See also Maltz* v. *Aetna Health Plans*, 152 F.3d 919 (2d Cir. 1998) (table).

remunerative care possible. Too much medical care, like too little, could harm patients; excessive medical treatment also increases the cost of health care generally. The point is not that an allegation that an ERISA plan provides fee-for-service health care states a claim for breach of fiduciary duty. Instead, the point is that neither fee-for-service nor managed care places the physician in a situation free of conflict. If a provider breaches ERISA whenever he or she makes health-care decisions operating under a financial conflict of interest, both fee-for-service and managed care are unlawful.[18]

For reasons touched on *supra* at 29-30, it is particularly ironic that the court of appeals extended the scope of ERISA fiduciary liability in a case involving a *physician-owned* managed-care plan. Physician-controlled health plans have been advocated as an antidote to the perceived tension between the goals of providing quality patient care and containing costs, because physicians' decisions are already governed by professional ethical codes and obligations and by the law of medical malpractice. See Hirshfeld, *supra*. These constraints ameliorate the conflict of interest inherent in the HMO structure, because physicians are less likely than other HMO owners to make business and medical judgments solely on the basis of financial interest.

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[18] It is possible that, under the court of appeals' decision, an ERISA fiduciary could attempt to prove that a particular form of managed care did not actually create a conflict of interest. But at the very least, the decision would "commit[] the court[s] to a long (and I should think unhappy) course of distinguishing 'good' managed-care systems from 'bad' ones." *See* App. 58a (Easterbrook, J., dissenting). Of course, the judiciary makes many judgments in specialized areas when the Constitution or the Congress requires it to do so, but the decision below would stretch ERISA out of its natural shape, ignore prior decisions of this Court, and partially nullify an act of Congress in order to appropriate these policy judgments for federal courts.

In sum, unlike the common law of trusts, ERISA contemplates that persons acting as ERISA fiduciaries may have divided loyalties. Accordingly, the bare allegation that petitioners have divided loyalties does not state a claim for breach of fiduciary duty under ERISA.

III. HERDRICH'S FAILURE TO ALLEGE DAMAGE TO THE PLAN DEMONSTRATES THAT SHE FAILED TO STATE A CLAIM FOR BREACH OF FIDUCIARY DUTY.

Herdrich's failure to allege damage to an ERISA plan provides a further demonstration that she has not stated a claim for breach of fiduciary duty under ERISA. According to Herdrich, "the [p]lan" was injured by the year-end financial distribution from HAMP to its owners, the Carle Clinic physicians. Complaint ¶ 13 (App. 87a). This argument necessarily assumes that the plan included a trust fund for the benefit of plan members and that these financial distributions were part of the corpus of that trust. State Farm, however, establishes no such trust. See generally App. 93a-128a (Group Subscription Certificate). Cf. 42 U.S.C. §§ 1102, 1103 (setting out the detailed requirements for establishing an ERISA trust in a plan).

Indeed, it is difficult to conceive of what purpose a trust would serve in the context of a health-care benefit plan. We assume *arguendo*, as Herdrich alleges in her Complaint (App. 84a), that the benefit provided by the ERISA plan is "arrang[ing] for medical and hospital services and other health care services to the Subscriber in accordance with the Subscription Certificate." App. 93a. Petitioners do not manage funds for participants and beneficiaries or administer any financial benefit which might necessitate the existence of a trust. Indeed, Herdrich does *not* claim that the financial distribution to the Carle physicians resulted in the denial of any benefit under

the plan -- *i.e.*, a failure to arrange medical or hospital services consistent with the terms of the Group Subscription Certificate. Thus, Herdrich's Complaint fails to allege any damage to the plan because the money paid to HAMP under its contract with State Farm is not part of any plan trust and the payment of some portion of that money to HAMP's owners does not deprive plan participants of any benefit promised under the plan.[19]

Even assuming (counter factually) that the plan included a trust for the benefit of subscribers, Herdrich's Complaint still fails to state a claim because her damages claim is fundamentally inconsistent with her theory of liability in two independent respects. *First*, Herdrich asserts (correctly) that the Carle physicians own HAMP. Complaint ¶ 2 (App. 84a). Thus, the Carle physicians are entitled to any proceeds properly earned by HAMP from delivering health-care benefits to plan participants. (As explained above, the money earned by HAMP from cost-containment mechanisms is the consideration HAMP receives from State Farm for arranging medical and hospital services for plan subscribers and cannot be considered part of a plan trust.) Accordingly, the financial distribution from HAMP to the Carle physicians does not deprive the plan of assets. It simply transfers HAMP's earnings to HAMP's actual owners.[20]

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[19] The absence of damage to the plan is underlined by an examination of section 409 of ERISA, which expressly addresses liability, and hence damages, for fiduciary breach. When a plan fiduciary breaches his or her duty, he or she is "personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary." 29 U.S.C. § 1109. This provision simply makes no sense here because there is no loss of any plan asset and no profit to any fiduciary based on the use of plan assets.

[20] Indeed, as the owners of HAMP, the Carle physicians can charge HAMP whatever fees they wish for their services. As a result, the physicians could

(continued...)

Second, Herdrich asserts that financial distributions paid to Carle physicians were obtained "[a]s a direct and proximate result of defendants' breach of their fiduciary duties." Complaint ¶ 13 (App. 87a). In other words, the money for the payments was earned by the conduct alleged to constitute a breach of fiduciary duty. Without the fiduciary breach, the plan would not have had this money to pay out to its physician owners as income. If that is so, it makes no sense to allege that payment of that money *damaged* the plan. With or without the alleged breach, the plan would not have had the money at issue.

Herdrich's failure to allege damage to an ERISA plan independently demonstrates that she has failed to state a claim for breach of fiduciary duty actionable under ERISA.

CONCLUSION

The decision of the court of appeals should be reversed.

[20] (...continued)
eliminate the end-of-the year distribution from HAMP merely by increasing the rates they charge HAMP. There is no independent economic significance to the financial distributions which HAMP's owners (the Carle physicians) make to the Carle Clinic Association (the Carle physicians). To the contrary, these distributions are simply accounting transactions.

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